BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
DAN TZUOH LEE, M.D. Certificate No. C-41308	)	No. 07-90-1386
Respondent	)	

DECISION

The attached Stipulation for Settlement is hereby adopted by the Division of Medical Quality as its Decision in the above-entitled matter.

This Decision shall become effective on September 10, 1997

IT IS OR ORDERED August 11, 1997.

By: _____
IRA LUBELL, M.D.
Chair
Division of Medical Quality

DANIEL E. LUNGREN, Attorney General
of the State of California
RICHARD AVILA,
Deputy Attorney General
California Department of Justice
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Los Angeles, California 90013
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Attorneys for Complainant

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **DAN TZUOH LEE, M.D.** **301 W. Huntington Drive** **Arcadia, CA 91007** **Physician's and Surgeon's Certificate No. C-41308,** **Respondent.**	**No. D-5171** **STIPULATION FOR SETTLEMENT**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

1. There is currently on file before the Medical Board of California (hereinafter "Board") an Accusation, dated April 14, 1993, in Case Number D-5171, directed against Dan Tzuoh Lee, M.D. (hereinafter "respondent").

2. Respondent acknowledges that he has been properly served with said Accusation and has reviewed it with his attorney of record, Albert J. Garcia, Esq. of the law offices of James Jay

Seltzer.

3. Respondent has discussed the instant Stipulation for Settlement with his counsel, including all admissions, stipulations and recitals contained herein, and fully understands its effect.

4. Respondent understands that but for this Stipulation for Settlement he has the right to a hearing on the charges and contentions in the Accusation, including the right to confront and cross-examine the witnesses against him, the right to counsel, the right to testify and present evidence in his own behalf, the right to issue subpoenas to compel the attendance of witnesses and the production of documents, the right to a written decision following a hearing, the right to reconsideration, appeal and any and all other rights accorded to him under the California Administrative Procedure Act and the California Code of Civil Procedure.

5. Respondent freely, voluntarily, knowingly and intelligently waives each of the rights set out at above numbered paragraph 4.

6. Respondent stipulates as follows:

A. The facts alleged in paragraphs 1 and 2 of the Accusation are true and correct.

B. As to the factual allegations contained in paragraphs 7 through 9 of the Accusation, complainant can establish a prima facie case as to said facts, and respondent waives his right to defend against them.

7. Pursuant to the stipulations in above numbered

paragraph 6, respondent agrees that the Board may take disciplinary action against Physician's and Surgeon's Certificate Number C-41308 under the authority of sections 2227 and 2234 of the Business and Professions Code.

8. All stipulations, admissions and recitals contained herein are made solely for the purpose of settling Case Number D-5171, and may not be used in any other proceeding, excepting a license denial or disciplinary proceeding maintained by a state medical board or similar federal or governmental agency.

9. In consideration of the foregoing admissions and findings, the parties stipulate and agree that the Board shall, without further notice or formal proceeding, issue and enter the following order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate Number C-41308, issued to respondent, Dan Tzuoh Lee, M.D., is revoked. However, said revocation is stayed and said certificate is placed on probation for three years on the following terms and conditions:

1. **ORAL OR WRITTEN EXAM**

Within sixty (60) days of the effective date of this decision, respondent shall take and pass an oral clinical examination in obstetrics and gynecology. If respondent fails this examination, respondent must take and pass a reexamination consisting of both a written examination and oral clinical examination. The waiting period between repeat examinations shall be at ninety (90) day intervals until success is achieved.

Respondent shall pay the cost of each examination.

If respondent fails the first examination, respondent shall cease the practice of medicine until the reexamination has been successfully passed, as evidenced by written notice to respondent from the Division of Medical Quality (hereinafter "Division") or its designee. Failure to pass the required examination one hundred (100) days prior to the termination date of the probationary period shall constitute a violation of probation.

2. **EDUCATION COURSE**

Within ninety (90) days of the effective date of the decision, and on an annual basis thereafter, respondent shall submit to the Division or its designee, for its prior approval, an educational program or course to be designated by the Division or its designee, which shall not be less than forty (40) hours per year, for each year of the probationary period. This program shall be in addition to the Continuing Medical Education requirements for relicensure. Following the completion of each course, the Division or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for sixty-five (65) hours of continuing medical education of which forty (40) hours were in satisfaction of this condition and were approved in advance by the Division or its designee.

3. **ETHICS**

Within sixty (60) days of the effective date of the decision, respondent shall submit to the Division for its prior

approval a course in Ethics, which respondent shall successfully complete during the first year of probation.

4. **MONITORING**

Within thirty (30) days of the effective date of the decision, respondent shall submit to the Division or its designee, for its prior approval, a plan of practice in which respondent's practice shall be monitored by another physician in respondent's field of practice, who shall provide periodic reports to the Division or its designee.

During the first year of probation, respondent shall submit to monthly inspection by his monitoring physician of his patients' hospital charts and spot checks of the patient charts maintained in his office. Any irregularities in treatment or charting shall be reported to the Board. During the second and third years of the probationary period, respondent shall submit to random checks of his patients' hospital and office charts by his monitoring physician.

If respondent's monitoring physician resigns or is no longer available, respondent shall, within fifteen (15) days of his monitor's resignation or unavailability, move to have a new monitor appointed, through nomination by respondent and approval by the Division or its designee.

5. **COST OF INVESTIGATION**

Respondent shall pay the sum of $1,350.00 as the reasonable costs of the investigation, pursuant to Business and Professions Code section 125.3. Said sum shall be paid to the Division or its designee within thirty (30) days of the effective

date of the decision. The filing of bankruptcy by respondent shall not relieve respondent of his responsibility to reimburse the Division for its investigative and prosecution costs.

6. **OBEY ALL LAWS**

Respondent shall obey all federal, state and local laws, and all rules governing the practice of medicine in California.

7. **QUARTERLY REPORTS**

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division or its designee, stating whether there has been compliance with all of the conditions of probation.

8. **SURVEILLANCE PROGRAM**

Respondent shall comply with the Division's probation surveillance program.

9. **INTERVIEW WITH MEDICAL CONSULTANT**

Respondent shall appear in person for interviews with the Division's medical consultant upon request at various intervals and with reasonable notice.

10. **TOLLING FOR OUT-OF-STATE PRACTICE OR RESIDENCE**

The period of probation shall not run during the time respondent is residing or practicing outside the jurisdiction of California. If, during probation, respondent moves out of the jurisdiction of California to reside or practice, respondent must notify the Division or its designee in writing of the dates of departure and, if applicable, his date of return.

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11. **MEDI-CAL REIMBURSEMENT**

Respondent's license shall not be affected by section 16.01 of the Budget Act of 1996, related to Medi-Cal reimbursement, since compelling circumstances exist that warrant continued Medi-Cal reimbursement during the probationary period.

12. **LICENSE SURRENDER OPTION**

Following the effective date of this decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may voluntarily tender his certificate to the Board. The Division reserves the right to evaluate the respondent's request and to exercise its discretion whether to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the tendered license, respondent will no longer be subject to the terms and conditions of probation.

13. **COMPLETION OF PROBATION**

Upon successful completion of probation, respondent's certificate will be fully restored.

14. **VIOLATION OF PROBATION**

If respondent violates probation in any respect, the Division or its designee, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an accusation or petition to revoke probation is filed against respondent during the probationary period, the Division or its designee shall have

continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

CONTINGENCY

This stipulation shall be subject to the approval of the Board. Respondent understands and agrees that Board staff and counsel for complainant may communicate directly with the Board members regarding this Stipulation for Settlement, without notice to or paticipation by respondent or his counsel. If the Board fails to adopt this Stipulation as its Decision and Order, the Stipulation shall be of no force or effect for either party, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action in this matter by virtue of its consideration of this Stipulation.

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ACCEPTANCE

I have carefully read and fully understand the Stipulation and Order set forth above. I have discussed the terms and conditions set forth in the Stipulation and Order with my attorney, Albert J. Garcia, Esq. I understand that in signing this Stipulation, I am waiving my right to a hearing on the charges set forth in the Accusation on file in this matter. I further understand that in signing this Stipulation the Board shall enter the foregoing Order placing certain requirements, restrictions and limitations on my right to practice medicine in the State of California.

DATED: 6/21/1997

DAN TZUOH LEE, M.D.
Respondent

APPROVAL AS TO FORM AND CONTENT

I have read the above Stipulation for Settlement and Disciplinary Order and approve same as to form and content. I have fully discussed the terms and conditions and other matters contained therein with respondent, DAN TZUOH LEE, M.D.

DATED: 7-9-97

ALBERT J. GARCIA
Attorney for Respondent

ENDORSEMENT

The attached Stipulation for Settlement is respectfully submitted for the consideration of the Board.

DATED: 7-9-97

RICHARD AVILA
Deputy Attorney General
DANIEL E. LUNGREN
Attorney General,
State of California

Attorneys for Complainant

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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DIVISION OF MEDICAL QUALITY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: DAN TZUOH LEE, M.D. 301 W. Huntington Drive Arcadia, CA 91007 Physician's and Surgeon's Certificate No. C41308 Respondent.	NO. D-5171 A C C U S A T I O N

The Complainant alleges:

BRIEF STATEMENT OF THE CASE

This case involves the treatment and management of 17 (seventeen) patients of Dr. Dan T. Lee. All of the incidents mentioned ***infra*** occurred at Garfield Medical Center, located at 525 N. Garfield Avenue in Monterey Park, California. Two of the incidents involved injury to infants delivered by Dr. Lee; ten of the incidents involved the mismanagement of the patients; and six of the incidents involved problems with Dr. Lee not being

available for treatment of his patients or delivery of their infants.

PARTIES

1. Complainant, Dixon Arnett, is the Executive Director of the Medical Board of California (hereinafter the "Board") and brings this accusation solely in his official capacity.

2. On or about March 26, 1977, Physician's and Surgeon's Certificate No. C41308 was issued by the Board to Dan Tzuoh Lee, M.D. (hereinafter "respondent"), and at all times relevant to the charges brought herein, said license has been in full force and effect.

JURISDICTION

3. This accusation is brought under the authority of the following sections of the California Business and Professions Code (hereinafter the "Code"):

4. Sections 2003 and 2004 of the Code provide, in pertinent part, that the Division of Medical Quality (hereinafter the "Division") within the Medical Board of California is responsible for the enforcement of the disciplinary provisions of the Medical Practice Act, for the administration and hearing of disciplinary actions, for carrying out disciplinary actions appropriate to findings made by a medical quality review committee, the division or an administrative law judge, and for suspending, revoking or otherwise limiting certificates after the conclusion of disciplinary actions.

5. Section 2227 provides that the Board may revoke, suspend for a period not to exceed one year, or place on probation,

the license of any licensee who has been found guilty under the Medical Practice Act.

6 Section 2234 provides that unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter.

(b) Gross negligence.

(c) Repeated negligent acts.

(d) Incompetence.

(e) ...

(f) ...

CAUSES OF ACTION

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GROSS NEGLIGENCE

7. Respondent Lee is subject to disciplinary action under section 2234(b) of the Code in that he repeatedly committed acts of negligence and incompetence which showed a pattern of gross negligence in his treatment and/or management of seventeen patients. The circumstances are as follows:

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A. **PRIMARY FACTUAL ALLEGATIONS**

(1) **PATIENT #1, BABY GIRL C.[1] (765672)[2]**

(a) On or about April 13, 1988, respondent was the primary physician handling the labor and delivery for prenatal patient Aifen C., the mother of Baby Girl C.

(b) During the delivery of Baby Girl C., respondent poorly applied and/or misapplied the forceps, causing a laceration above the eyebrow of the infant.

(c) This case involves injury to an infant.

(2) **PATIENT #2, MARIA A. (765883)**

(a) On or about March 18, 1988, respondent's 27 year-old prenatal patient Maria A. was admitted to the hospital for labor and delivery of a child.

(b) At approximately 12:15 A.M., respondent was telephoned regarding patient Maria A.; his telephone line remained busy and he could not be reached.

(c) Maria A.'s baby was delivered by another physician at 2:10 A.M.on March 18, 1988.

(d) Respondent was not available for the delivery of his patient.

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1. For privacy reasons, only the initials of the last name of the respective patients will be used in this accusation. The names of the patients will be provided to respondent in discovery, if requested.

2. The number in parenthesis refers to the patient's hospital chart number given by Garfield Medical Center.

(3) **PATIENT #3, HELEN V. (762520)**

(a) On or about February 10, 1988, respondent's 29 year-old prenatal patient Helen V. was admitted into labor and delivery.

(b) Respondent examined this patient at 7:00 A.M. at the hospital. He subsequently left the hospital.

(c) The labor and delivery section of the hospital telephoned the respondent regarding Helen V. at 12:30 P.M., 1:00 P.M., 1:30 P.M., 2:00 P.M., 3:00 P.M., 3:30 P.M. and 5:00 P.M., all without a response.

(d) Respondent Lee arrived at the hospital at 6:30 P.M.

(e) The respondent was unavailable for the treatment and management of patient Helen V.

(4) **PATIENT #4, TERESA S. (762943)**

(a) On or about February 11, 1988 respondent's 18 year-old prenatal patient Teresa S. was admitted to the hospital at 11:25 A.M.

(b) Respondent was beeped at 1:10 P.M. regarding patient Teresa S.; respondent did not respond to his beeper.

(c) Patient Teresa S. gave birth at 1:57 P.M., attended by another physician.

(d) Respondent Lee was unavailable for the delivery of this patient.

(5) **PATIENT #5, CHAU T. (748866)**

(a) Respondent Lee was the primary physician for 32 year-old prenatal patient Chau T.

(b) Patient Chau T. reported that she had been having a dark brown discharge and a pink fluid discharge since June 1, 1988, a Wednesday.

(c) On June 2, 1988, patient Chau T. was seen in the respondent's office and given an ultrasound.

(d) There is no documentation in the respondent's medical records for patient Chau T. that respondent had examined said patient for a rupture of the membranes on 6-2-88, nor is there any documentation in her medical records that respondent Lee performed a follow-up examination for rupture of membranes.

(e) Patient Chau T. related that on June 4, 1988, a Saturday, she had pain.

(f) On or about June 5, 1988 at 8:30 A.M. patient Chau. T. was admitted to the hospital with a premature rupture of the membranes associated with symptoms of infection.

(g) The patient was at 26 weeks gestation.

(h) Patient Chau T. had a temperature of 101.2 with fetal tachycardia (increase in fetal heartbeat).

(i) Fetal tachycardia is a sign of possible fetal distress.

(j) A premature infant, weighing 1 pound, 13 ounces was delivered via Cesarian Section by the respondent at 9:02 P.M.

(6) **PATIENT #6, IRIS R. (770009)**

(a) On or about June 29, 1988 at approximately 8:00 P.M. respondent's 29 year-old prenatal patient Iris R. was admitted to the hospital with questionable fetal heart tones.

(b) At 9:04 P.M., a stillborn girl was delivered via Cesarian Section by the respondent.

(c) There was no documentation in respondent's prenatal records for patient Iris R. that she was given urine checks to determine the level of her blood sugar, a standard in the care and treatment of pregnant women.

(7) **PATIENT #7 MARIA T. (766622)**

(a) On or about March 31, 1988 at approximately 8:30 P.M., respondent's 28 year-old patient Maria T. was admitted to the hospital with her cervix dilated to 7-8 centimeters.

(b) On or about April 1, 1988 at approximately 12:24 A.M. the patient sustained a rupture of the membranes.

(c) At 2:50 A.M., the patient's cervix had dilated to 9 centimeters.

(d) Patient Maria T. was taken to respondent Lee at 2:55 A.M. for delivery.

(e) At 3:00 A.M. respondent Lee disappeared from the delivery room.

(f) At 3:03 A.M., patient Maria T. was delivered by the nursing staff.

(g) At 3:05 A.M. respondent Lee reappeared.

(h) The respondent was unavailable for patient Maria T.'s delivery.

(8) **PATIENT #8, DEBBY T. (757677)**

(a) On or about November 26, 1987 at 2:40 P.M. respondent's 27 year-old prenatal patient Debby T. was admitted to the hospital at term and in active labor.

(b) There was no documentation in respondent's prenatal records for patient Debby T. that she was given urine checks to determine the level of her blood sugar, a standard in the care and treatment of pregnant women.

(c) Respondent Lee did not use Pitocin in an attempt to bring the patient's contractions closer together.

(d) Pitocin is a drug used for the initiation or improvement of uterine contractions.

(e) Patient Debby T. did not progress in labor due to a cephalopelvic disproportion, a condition in which the baby's head is too large or the mother's birth canal is too small for normal labor or birth.

(f) Respondent Lee delivered patient Debby T. via Cesarian Section on November 27, 1987 at 2:32 A.M.

(9) **PATIENT #9, KAREN R. (762484)**

(a) On or about January 23, 1988 at approximately 7:00 A.M., 22 year-old patient Karen R. was admitted to the hospital via transfer from another facility complaining of generalized weakness, fever, chills, low abdominal pain and continued watery, bloody discharge for the past 2-3 days. Karen R. was in her 21st or 22nd week of pregnancy as measured by sonogram, but in her 29th week by date. Respondent began treating patient Karen R. at the hospital.

(b) Karen R.'s white blood cell count was 30,000, an indication of infection.

(c) Karen R. was leaking a brownish bloody fluid from her vaginal area and experiencing contractions every 2-3 minutes.

(d) The fetal heart tone was 160-170.

(e) Karen R. had a temperature of 100.4°.

(f) Respondent diagnosed her has having a premature rupture of the membranes.

(g) Respondent also diagnosed Karen R. as having acute chorioamnionitis which is a swelling in the fetal membranes caused by organisms in the fluid surrounding the fetus.

(h) The respondent did not want cultures to be taken to determine the presence of infection.

(i) The respondent, after consultation with another physician agreed upon termination of pregnancy due to maternal infection.

(j) Patient Karen R. agreed to the termination of her pregnancy.

(k) The respondent administered Prostin E and the labor progressed.

(l) Respondent started antibiotics without prior cultures.

(m) At approximately 6:25 P.M., respondent delivered a baby girl; the baby had a heartbeat and Apgar 1-1.

(n) The respondent told the nursing staff to "forget it; baby is dead."

(o) The respondent did not call a pediatrician to assist with the infant and in fact, the respondent refused the request for a pediatrician tendered by the nursing staff.

(p) The baby and the placenta were covered with a pus-like substance.

(q) At 6:45 P.M., the baby was transferred to the Neonatal Intensive Care Unit (NICU) due to a persistent heartbeat.

(r) The baby died at 8:10 P.M. in NICU.

(10) **PATIENT #10, ISABELL B. (751274)**

(a) On or about November 1, 1987 at approximately 5:30 P.M., respondent's 39 year-old

prenatal patient, Isabell B., arrived by ambulance from another facility at the request of the respondent.

(b) This was Isabell B.'s sixth pregnancy and she had a history of 35 minute labor; she was in her seventh month of pregnancy and her bag of water had broken.

(c) When Isabell B. arrived at the hospital, her cervix was dilated to 4 centimeters and she was passing thick meconium, a sign of possible fetal distress.

(d) The respondent did not accompany Isabell B. in the ambulance.

(e) Isabell B. was delivered by nursing staff at 5:53 P.M.

(f) Respondent Lee was unavailable for the delivery of patient Isabell B.

(11) **PATIENT #11, MONIQUE S. (741173)**

(a) On or about November 25, 1987, respondent Lee performed a D&C on patient Monique S. During the surgery, the respondent perforated the uterus of Ms. S.

(b) The respondent did not document in his written account of the surgical procedure that he had perforated the uterus of Monique S.

(c) The respondent sent Monique S. home without instructions regarding the perforation of her uterus.

(d) The respondent did not take precautions against possible infection such as prescribing antibiotics.

(e) On or about November 30, 1987, patient Monique S. was readmitted to the hospital after complaining of abdominal pain and vomiting; she was admitted with acute abdominal pain and acute peritonitis which is a swelling of the membrane that covers the wall of the abdomen.

(f) Diagnostic Imaging on November 30, 1987 indicated findings consistent with a perforated hollow viscus or uterus in patient Monique S.

(g) Patient Monique S. required surgery nine days after the D&C due to the infection.

(12) **PATIENT #12, CHANDRA V. (777015)**

(a) On or about September 20, 1988 at 7:15 A.M., respondent's 30 year-old prenatal patient, Chandra V. was admitted to the hospital for delivery.

(b) Dr. Lee said that he checked her at noon.

(c) Patient Chandra V. entered the second stage of labor at 2:45 P.M..

(d) At 3:30 P.M., patient Chandra V. was taken to the delivery room crowning, the phase at the end of labor in which the baby's head is see at the opening of the vagina.

(e) Respondent Lee was paged at 3:30 P.M. regarding patient Chandra V. He did not respond.

(f) At approximately 3:30 P.M., respondent Lee's office was also telephoned regarding patient Chandra V. The respondent was not in his office.

(g) Respondent Lee arrived at the hospital at 4:05 P.M.

(h) Patient Chandra V.'s baby was delivered at 4:08 P.M.

(i) Respondent Lee was unavailable for the care and management of patient Chandra V.

(13) **PATIENT #13, BABY BOY P. (775561)**

(a) On or about August 25, 1988, respondent Lee was the primary physician handling the labor and delivery for prenatal patient Estela P., the mother of Baby Boy P.

(b) During the delivery of Baby Boy P., respondent poorly applied and/or misapplied the forceps, causing excessive bruising over the left eye and temporal area of the infant with swelling over the right ear.

(c) This case involves injury to an infant.

(14) **PATIENT #14, JACKIE T. (777241)**

(a) On or about October 1, 1988 at 11:30 P.M. 24 year-old prenatal patient Jackie T. called respondent to report that she had felt no fetal movement.

(b) Respondent advised Jackie T. to rest.

(c) The nursing staff telephoned respondent at approximately 24:00 (midnight on October 1, 1988, going into October 2, 1988) to report that patient Jackie

T. was at the hospital. The patient had no fetal heart tones.

(d) Respondent advised the nurse to tell the patient to go home and return later in the morning (October 2, 1988) for an ultrasound to determine fetal viability.

(e) Jackie T. was admitted to the hospital on October 2, 1988 at approximately 12:20 P.M.

(f) The ultrasound, done at 1:40 P.M., confirmed the absence of fetal movement and cardiac activity.

(g) On two tests for blood sugar, Jackie T. had a glucose count of 800 and 880, indicating that she was diabetic.

(h) There was no documentation in respondent's prenatal records for patient Jackie T. that she was given urine checks to determine the level of her blood sugar, a standard in the care and treatment of pregnant women.

(i) Induction of labor was initiated but the patient did not progress. A Cesarean Section was performed by respondent at approximately 5:57 P.M. on October 3, 1988, delivering the dead fetus.

(15) **PATIENT #15, PATRICIA A. (775255)**

(a) On or about August 19, 1988 at 8:50 P.M., respondent's 22 year-old prenatal patient was admitted to the hospital for a premature rupture of the membranes and early labor. She was in her 38th week of pregnancy.

(b) The respondent administered Pitocin augmentation for two hours, starting at 11:00 P.M. then discontinued it.

(c) The respondent performed a Cesarian Section on patient Patricia A. on August 20, 1988 at 9:38 A.M., after approximately six hours of inadequate labor.

(16) **PATIENT #16, DIANE M. (773141)**

(a) On or about July 15, 1988, respondent's 23 year-old prenatal patient Diane M. was admitted to the hospital at term for delivery with a rupture of the membranes.

(b) Patient Diane M. did not progress in labor because of a cephalopelvic disproportion.

(c) Respondent performed a Cesarian Section of patient Diane M. at 9:11 A.M., some six hours after the patient had reached complete dilation at 3:15 A.M.

(17) **PATIENT #17, MARY E. (769370)**

(a) On or about May 25, 1988, respondent's 22 year-old prenatal patient Mary E. was admitted for delivery.

(b) The respondent did not document in his medical records for patient Mary E. that she had a prior history of herpes, with a fresh outbreak thereof two weeks prior to her admission to the hospital for delivery.

(c) Respondent did not inform the nursing staff that patient Mary E. had a history of herpes.

(d) Respondent performed a Cesarian Section on patient Mary E.

B. **ALLEGATIONS OF GROSS NEGLIGENCE**

(1) In violation of section 2234(b) of the Code, Respondent Lee committed gross negligence in his treatment and/or care of seventeen patients by a continued pattern of negligence and incompetence as follows:

(a) Respondent failed to give routine urine checks to determine the level of blood sugar in prenatal patients Iris R., Debby T., Jackie T. and Diane M.-- patient numbers 6, 8, 14 and 16, respectively.

(b) Respondent failed to make himself available to care for the imminent needs of patients Maria A., Helen V., Teresa S., Maria T., Isabell B. and Chandra V.-- patient numbers 2, 3, 4, 7, 10 and 12, respectively.

(c) Respondent failed to make himself available for the delivery of patients Maria A., Teresa S., Maria T. and Isabell B, causing another physician or the nursing staff to effectuate the delivery of infants of said patients -- numbers 2, 4, 7 and 10, respectively.

(d) Respondent failed to properly apply forceps in delivering infants Baby Girl C. and Baby Boy P., patient numbers 1 and 13, respectively, causing injury to each of the infants.

(e) Respondent failed to properly treat, care for or prescribe Cesarean sections for patients Iris R.,

Isabell B., Patricia and Mary E.--patient numbers 6, 10, 15 and 17, respectively.

(f) Respondent failed to properly evaluate the condition of and/or failed to properly prescribe an appropriate treatment and management plan for patients Chau T., Karen R. and Monique S.-- patient numbers 5, 9 and 11, respectively.

(1) Respondent failed to properly evaluate patient Chau T.'s (patient #5) condition of premature rupture of the membranes when she first complained of a dark brown and/or pink discharge three days before she was admitted to the hospital with symptoms of infection.

(2) Respondent failed to order cultures to determine the presence of infection in his treatment of patient Karen R. (patient #9).

(3) Respondent failed to order cultures prior to prescribing antibiotics for patient Karen R. (patient #9)

(4) Respondent failed to document in his surgical records that he had perforated the uterus of patient Monique S. (patient #11).

(5) Respondent failed to advise patient Monique S. that her uterus had been perforated and respondent failed to take precautions against infection prior to releasing said patient from the hospital.

II

REPEATED NEGLIGENT ACTS

8. Respondent Lee is subject to disciplinary action under § 2234(c) of the Code in that he has committed and attempted to commit repeated negligent acts in his treatment and management of the seventeen patients mentioned ***supra*** in paragraph 7. The circumstances are as follows:

A. The facts as alleged in paragraph 7, including any subparagraphs and subdivisions therein are hereby incorporated by reference and made a part hereof.

III

INCOMPETENCE

9. Respondent Lee is subject to disciplinary action under § 2234(d) of the Code in that he was incompetent in his treatment and management of the seventeen patients mentioned ***supra*** in paragraph 7. The circumstances are as follows:

A. The facts as alleged in paragraph 7, including any subparagraphs and subdivisions therein are hereby incorporated by reference and made a part hereof.

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PRAYER

WHEREFORE, the complainant requests that a hearing be held on the matters herein alleged, and that following said hearing, the Board issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number C41308, heretofore issued to respondent Dan Tzuoh Lee, M.D.;

2. Taking such other and further action as the Board deems proper.

DATED: April 14, 1993.

DIXON ARNETT
Executive Director
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Complainant